Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UNIVERSITY HEALTH SYSTEM
4502 MEDICAL DR
SAN ANTONIO TX 78229

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
UTICA MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-09-0003-01

MFDR Date Received
AUGUST 28, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have reviewed the attach claim and found that the claim was denied. This claim has over to in a judgment of patient favor, this claim should be consider due the judgment so additional payment of $4,5360.8 [sic] University Health System has received a denial on its appeal."

Amount in Dispute: $4,536.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "UHS did not bill us timely. They did send us a bill on 6/4/08, which we responded to with a DWC-62. The reason we denied their claim was because of untimely filing. Additional, UHS failed to preauthorize the service provided as required under Rule 134.600."

Response Submitted by: Utica Mutual Insurance, PO Box 6554, Utica, NY 13504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2007	Outpatient Hospital Services	$4,536.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 29 – The time limit for filing has expired.

Findings

1. A Benefit Review Conference was held on January 3, 2008, to mediate resolution of the disputed issues, however, the parties were unable to reach an agreement. A contested Case Hearing was held on February 25, 2007. It was the decision of the hearing officer that the claimant sustained a compensable injury on August 27, 2007. The hearing officers' decision was appealed; the Appeals Panel upheld the decision of the hearing officer; accordingly, this constitutes notice that the Hearing Officer's Decision and Order signed on March 12, 2008 became final on June 2, 2008.
2. In accordance with 28 Texas Administrative Code §133.307(c)(1)(B)(i) A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request may be filed later than one year after the dates(s) of service if a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. The 60th day after the decision was upheld was August 1, 2008; the request for medical fee dispute resolution was received in the Division on August 28, 2008. Therefore, the dispute was not timely filed and the merits of the dispute cannot be reviewed.

Conclusion

The Division further concludes that the requestor failed to timely file the request for medical dispute resolution to the Division. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 31, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.